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Deceased Organ Donation: In Praise of Pragmatism*

Vigorous debate about the ethics of obtaining sufficient organs for transplant has enthralled scholars and the media ever since the first successful kidney transplant. Should "donors" be paid? Would presumed consent for cadaver organs result in more organs for transplant? Should all cadaver organs become the property of the state? Thousands of papers have been written. Yet in the United Kingdom the number of patients waiting for a transplant continues to rise and too many patients die waiting.[1] No-one is winning the ethical debate. While ethicists and lawyers argue, people die. There is one odd aspect of debates on the ethics of transplantation which makes such debates different from arguments about other ethical controversies. Nearly all parties are agreed about the ends – we agree that transplants are a good. We want to find the means of ensuring a sufficient supply of organs for transplant. We just disagree about *how* this ought to be done.

With this in mind the Centre for Social Ethics and Policy sought funding from the Economic and Social Research Council for a five part seminar series entitled "Transplantation and Organ Deficit in the UK: Pragmatic Solutions to Ethical Controversy".[2] The key word is "pragmatic". The seminar group contains physicians, philosophers, social scientists, lawyers, and family representatives and encompasses diverse ethical opinions. Participants were in part chosen because they have in the past disagreed with each other. The one rule at seminars is that everyone must put aside their own ethical preferences and focus on *practical*, realistic options to reduce the organ deficit.

If we focus here on deceased donation, a good place to make this start is to ask where opportunities for donation are being missed. A look at the figures from the Potential Donor Audit is illuminating in this respect. This is an audit of all deaths in Intensive Care Units (ICUs) around the United Kingdom. At first glance, it might appear that things are not too dire with family refusal to remove organs for transplant after a relative's death being only 40% and 45%, respectively, for brain stem dead and non-heart beating (NHB) donations.[4] Closer examination, however, reveals that these figures do not represent refusal rates regarding *all* potential donors in ICU. Instead it corresponds to the refusals amongst those families who were *actually* asked about donation. Of those patients who could have been considered as potential donors, there was no record of the families being approached in 15% of cases of those with a diagnosis of brain stem death[5] and 78% of potential non-heart beating donors.[6] In addition to this, there appear to be other missed opportunities including not testing for brain stem death, not considering patients with a diagnosis of brain stem death for organ donation, and not considering patients for NHB donation.[7] The cumulative effect of these missed opportunities is that from 2004 to 2006 only 31% of

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possible brain stem dead donors and 4% of possible non-heart beating donors became actual solid organ donors.[8]

What could we do to make the current system for deceased donation work better and to reduce these missed opportunities? Recent media focus has been on law reform with the Chief Medical Officer for England, Sir Liam Donaldson, backing a change in the law to a system of presumed consent.[3] And the Secretary of State for Health has now asked the Organ Donation Taskforce to consider such a change in the law. Is law reform that important? Within our group, we discern (maybe wrongly) that some degree of consensus seems to be emerging that laws do not matter as much as other factors. Proponents of presumed consent often cite Spain as incontrovertible evidence that it is presumed consent which results in better rates of organ donation. Spain is the most successful country in the world with 33.8 deceased donors pmp.[7] But Greece with one of the lowest rates in Europe also has a legal framework based on presumed consent. In Spain, donation rates did not start to rise for ten years after Spain changed the law. It was the introduction of an organisation to coordinate all aspects of donation activity, the Organizacion Nacional de Trasplantes (ONT), which made the difference. Donation activity is coordinated at national, regional, and local levels, with highly trained and qualified physicians taking on the role of transplant co-ordinators and being responsible for, *inter alia*, donor detection and approaches to families. Hospitals which provide donors receive suitable re-imbursement so that encouraging donation is seen as part of a hospital's core role. In practice, Spanish transplant co-ordinators always consult relatives and never take organs against the objections of the family. Accordingly the UK could adopt most of the model implemented in Spain without introducing presumed consent. Other practical measures could be taken swiftly to increase the numbers of both deceased and living donors. Staff in intensive care units could be encouraged to play a greater role in identifying potential donors and even approaching families before the moment of legal death.

Additionally steps could be taken to clear up confusion over what the current law does and does not sanction in relation to organ donation and potential organ donors. For instance, anecdotal evidence suggests that there is some confusion amongst intensive care staff over the application of legal rulings on 'best interests' to potential non-heart beating donors. This confusion leads to reluctance to take measures in advance of legal death which may enhance the chance of a patient becoming a non-heart beating donor. This reluctance may be one of the reasons why there is a disparity, shown above, in the conversion rates of possible to actual brain stem dead and non-heart beating donors (30% as opposed to 4%). In reality, those of us who want to be organ donors would also wish that everything possible be done to maximise the likelihood of our wishes being realised once any hope of recovery is lost. The law, especially the Mental Capacity Act 2005, can only be seen as supportive in this respect.

Reforming the law to allow presumed consent may seem an attractive option to address the disparity between the number of patients awaiting a transplant and the number of organs donated for transplant. Yet the Human

Tissue Act 2004 has barely been in force for a year. Parliamentary time for amendment may not be forthcoming. While there is also progress which could undoubtedly be made in relation to living organ donation our focus here has been on practical measures to increase the number of deceased donor organs available for transplantation In this respect it is our contention that there are a range of practical measures that can be instituted within the current legal framework that could make a real impact on the numbers of organs available for donation without reopening the bitter battles around the Human Tissue Act which may do little to promote the benefits of transplant medicine.

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